

MDR Tracking Number: M5-04-4087-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 7-30-04.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The office visit dated 8-1-03 **was found** to be medically necessary. The remaining ultrasound therapy, therapeutic exercises and manual therapy **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to date of service 8-1-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 24th day of September, 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division
DA/da

September 17, 2004

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-04-4087-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

- letter of medical necessity 08/27/04
- initial and progress reports 10/05/99 & 08/01/03
- S.O.A.P. note 08/01/03
- spine surgeon evaluations 11/30/99 & 04/19/00
- pain management evaluation 06/23/03
- NCV 11/08/99
- Impairment rating 10/25/00

Information provided by Respondent:

- correspondence & summary of position statement
- case review 07/01/03

Clinical History:

The patient was injured on the job on ___. He was evaluated and received medication and physical therapy. However, he continued to experience ongoing problems. On October 5, 1999, he sought care in another doctor's office. An evaluation was performed, which revealed sufficient objective findings to warrant additional diagnostic testing and an aggressive treatment program. In addition, appropriate referrals to other

doctors were made. Diagnostic testing in the form of MRI and electrodiagnostic testing confirmed the patient's injuries.

Over the course of treatment, the patient received chiropractic care, therapy, medications, and injection therapy. It was determined that due to the patient's morbid obesity; surgery was not pursued, although necessary. The patient had completed a chronic pain management program and was to follow up in his treating doctor's office on a p.r.n. basis when experiencing increasing pain.

Disputed Services:

Office visits, ultrasound therapy, therapeutic exercises and manual therapy on 08/01/03.

Decision:

The reviewer partially disagrees with the determination of the insurance carrier and is of the opinion that the office visit on 08/01/03 was medically necessary in this case. However, ultrasound therapy, therapeutic exercises and manual therapy were not medically necessary in this case.

Rationale:

National treatment guidelines allow for this type of treatment for this type of injury. This patient's condition does warrant an occasional office visit for evaluation and management of his ongoing problems. There are no guidelines that allow for ongoing therapy 4 years after the patient's injury. By this time, the patient should have been appropriately instructed in a home exercise program as well as appropriate activities of daily living, and there was no need for passive therapy, therapeutic exercises, or manual therapy on this date of service. It was reasonable, usual, customary, and medically necessary for the patient to receive office visits on 8/1/03 in order to appropriately evaluate and manage his injury.

Sincerely,